

**State of Vermont**  
**Department of Vermont Health Access**  
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*Agency of Human Services*

### **Prescription for Pulse Oximeters-all ages**

*Please give this completed form to the patient or send directly to the DME supplier. DO NOT send to the Department of Vermont Health Access or to HP. Thank you.*

#### **Section I: Prescribing Provider**

Date of Request \_\_\_\_/\_\_\_\_/\_\_\_\_

Check one: \_\_\_\_Initial request      \_\_\_\_Renewal      \_\_\_\_Rental Only      \_\_\_\_Purchase

Patient Name \_\_\_\_\_

Medicaid ID \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

#### **Pulse Oximeter Requested:**

\_\_\_\_ \*Continuous w/24hr trending memory OR

\_\_\_\_ \*Continuous (non-hospital grade) alarms, memory print-out, ac/dc OR

\_\_\_\_ Spot check only:

*\*Usually rental only*

#### **Medical Necessity: *Attached supporting medical documentation.***

Estimate the length of time oximeter will be needed: Less than 3mos \_\_\_\_ 6mos \_\_\_\_ 12mos \_\_\_\_

Greater than 12 months \_\_\_\_ if so please explain: \_\_\_\_\_

\_\_\_\_\_

Describe treatment plan: \_\_\_\_\_

\_\_\_\_\_

Please explain why this model is the only model that will meet the needs of this patient at this time: \_\_\_\_\_

\_\_\_\_\_

Has the caregiver been trained on how to use the pulse oximeter, interpret the readings and actions to take? Yes \_\_\_\_ No \_\_\_\_



## Section II: Provider Information

Requesting physician's specialty: \_\_\_\_\_

Physician's name: \_\_\_\_\_

VT. Medicaid Provider Number \_\_\_\_\_ NPI Provider No. \_\_\_\_\_

Physician's address: \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

I certify that the item prescribed above is a medically necessary part of the course of treatment and is neither for *precautionary* or "*standby*" purposes nor for care giver convenience.

Physician's signature \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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## Section III: DME Provider

Information on equipment being placed in home (if new) or already in home (if renewal):

Brand: \_\_\_\_\_ Model: \_\_\_\_\_

Model #: \_\_\_\_\_ Serial #: \_\_\_\_\_

Warranty: Yes \_\_\_ No \_\_\_ Terms: 90 day \_\_\_ 1-Year \_\_\_ 2-Year \_\_\_ 3-Year \_\_\_ Other \_\_\_\_ (specify)

Date Caregiver trained by Respiratory Therapist: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name and credentials: \_\_\_\_\_

Date equipment last maintained: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date Respiratory Therapist last visited home: \_\_\_\_/\_\_\_\_/\_\_\_\_

Procedure Code: \_\_\_\_\_ Date of Service \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

I certify that the above described equipment is appropriate for the needs of the beneficiary as scripted by the physician *and* is consistent with Vermont Medicaid's criteria for oximeters.

Supplier/Vendor Name \_\_\_\_\_

Provider # \_\_\_\_\_

Address: \_\_\_\_\_

Telephone # \_\_\_\_\_ Fax # \_\_\_\_\_

DME Rep Name (print) \_\_\_\_\_

DME Rep Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*Note: All records are subject to retrospective review by the Department of Vermont Health Access.*